Chesterfield Orthodontics
8092 Edwin Raynor Blvd., Suite C
Pasadena, MD 21122
410-255-0200
www.cforthodontics.com

Dr. Robert Yoon

Patient's Name ____________________ Preferred name: ____________________

Address: ____

Birth Date: __________ Age: ______ Gender: __________ General Dentist: ____________________

Email for Appointment Reminders: ____________________ Phone number for reminders: ______________

Whom may we thank for referring you to our office? ________________________________

Other Family Members in Treatment: ________________________________

RESPONSIBLE PARTY INFORMATION:

Name: ____________________________ **Marital Status:** __________
Home Address: ____
Social Security Number: ______________ **Birth Date:** __________ **Relationship:** __________
Email: ______________ **Home Number:** ______________ **Cell Number:** ______________
Employed By: ____________________ **Occupation:** ____________________

SPOUSE'S INFORMATION:

Name: ____________________________ **Marital Status:** __________
Home Address: ____
Social Security Number: ______________ **Birth Date:** __________ **Relationship:** __________
Email: ______________ **Home Number:** ______________ **Cell Number:** ______________
Employed By: ____________________ **Occupation:** ____________________

Primary Dental Insurance Info:
Policy Holder's Name: ______________ **Birth Date:** __________ **SSN:** ______________
Insurance Company: ______________ **Insurance Co. Phone Number:** ______________
Insurance Company Address: ____
Member ID Number: ____________________ **Group Number:** ____________________

Secondary Dental Insurance Info:
Policy Holder's Name: ______________ **Birth Date:** __________ **SSN:** ______________
Insurance Company: ______________ **Insurance Co. Phone Number:** ______________
Insurance Company Address: ____
Member ID Number: ____________________ **Group Number:** ____________________

Emergency Contact Info:
Name: ____________________________ **Relationship to Patient:** ______________
Address: ________________________________ **Phone Number:** ______________

Patient's Signature: ________________________________ **Date:** ______________

Health Questionnaire

Date: __________

Patient's Name: ____ **Birth Date:** ____________

Date of Last Dental Visit: _______________________ **Family Physician:** _____________________

Have you ever had the following?

Orthodontic Consultation: Y/N **Date:** _________________ **Dr.** _________________________________

Orthodontic Treatment: Y/N **Date:** _________________ **Dr.** _________________________________

Do you have or have you had any of the following oral conditions?

Y	N	Sensitive teeth	Y	N	Bleeding gums	Y	N	Oral habits (thumb sucking, etc)
Y	N	Clenching or grinding	Y	N	Pain around ear	Y	N	Pain in the jaw, face
Y	N	Jaw joint sounds or pain	Y	N	Pain when opening mouth	Y	N	Jaw joint sounds or pain
Y	N	Bad breath	Y	N	Dry mouth	Y	N	Mouth breathing
Y	N	Poorly functioning teeth	Y	N	Food wedging between teeth	Y	N	Inability to floss between teeth
Y	N	Discolored teeth	Y	N	Swelling or lumps in the mouth	Y	N	Tobacco use

Do you have or have you had any of the following medical conditions?

Y	N	Rheumatic fever	Y	N	Congenital heart lesions/murmur	Y	N	Heart condition
Y	N	Diabetes	Y	N	Arthritis, swollen joints	Y	N	Tuberculosis
Y	N	Kidney problems	Y	N	Swallowing problems	Y	N	Hepatitis type _________.
Y	N	Asthma	Y	N	Inflammatory Rheumatism	Y	N	Convulsions or seizure
Y	N	Liver disease	Y	N	Yellow jaundice	Y	N	Sinus problems
Y	N	Severe headaches	Y	N	High blood pressure	Y	N	Low blood pressure
Y	N	Eye problems	Y	N	Dizziness or fainting	Y	N	Venereal disease
Y	N	Nose bleeds	Y	N	Ear problems	Y	N	Anemia
Y	N	Easy bruising	Y	N	Speech problems	Y	N	HIV positive
Y	N	ADD/ADHS						

Is patient allergic to latex, metal or vinyl? If yes, please explain: ____

Is patient currently under a physician's care? If yes, please describe ____

Has patient ever been hospitalized or had any serious illness? If yes, please describe _________________________

____

Does patient have any drug allergies? If yes, list medications ____

Is patient taking any medications? If yes, list medications ____

____

Does patient have any food allergies? If yes, please Explain: ____

Female patients – could patient possibly be pregnant at the present time? __________________________________

Has patient ever taken any medication for osteoporosis? ____

Patient's Signature: ____ **Date:** _______________